SAM HO

November 11, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: Your date of birth?

Ho: November 26, 1950.

Mullan: Dr. Ho and I are sitting in my room at the Doubletree Hotel at the Los Angeles Airport. Not the most scenic venue, but not a bad room. It's the evening of the 11th of November 1996, and Dr. Ho was good enough to stop by on his commute from south to north, from Cypress, is it?

Ho: Yes.

Mullan: To Sherman Oaks, along the 405. Just a pit stop on the 405, to talk about himself. [Laughter] Thank you for stopping. You didn't always live on 405. You started somewhere else. Why don't you tell me where you were born and grew up.

Ho: I was born and raised in Honolulu, Hawaii. My upbringing was kind of a modest middle-class existence. My father was a third generation of Chinese-American in Honolulu, and a physician serving pretty much a blue-collar population in and around

Chinatown in Honolulu, and my mom was first generation from Beijing, but she was also very much Americanized.

Mullan: First generation, as she was born?

Ho: She was born in Beijing, but she came from a diplomat's family, so she grew up Americanized. She went to American School in Beijing, and she went to college at Smith, so we grew up very much the Chinese-American family. So, I was born and raised in Honolulu. My father, actually, in retrospect, served very much as a role model. He was a fairly modest man, worked as a general practitioner. Worked in Chinatown, like I said. He worked with a lot of impoverished people.

Mullan: Is Chinatown--I've never been to Hawaii--

Ho: Chinatown demographically had a lot of older single Filipino men, lots of blue-collar Chinese-American families, and in and around that area, lots of South Pacific Islanders, a lot of Samoan patients, a lot of ethnic Hawaiian patients.

So he had a solo practice, again, a one-exam-room office, with a ceiling fan, and rattan furniture. I spent a lot of time in his office, in his office waiting room, particularly on Sundays. He would have Sunday hours. After I went to church and Sunday school, and all those things that good middle-class families did, I would just wait in his waiting room. In retrospect, it was a very rewarding experience. I didn't know

that at the time. I thought it was just a way to pass the Sunday mornings, but to see his relationship with his patients as they would come out, saying, "Thank you," and he would be always very supportive of whatever their issues were. His demeanor was always very supportive. Taking calls all hours of the night. He was always on call for himself, and that was seven days a week, rarely, if ever, taking vacations. I think that was a rewarding legacy for me.

Mullan: Where had he gone to medical school?

Ho: He had gone to medical school near Boston, at a school that no longer exists, Middlesex Medical College in Sussex County.

Mullan: It was sort of the last of the schools that Flexner nailed. I knew people who went there. Like in the fifties, it closed, or something.

Ho: He went there during the war years, actually, '41 to '45. Did his internship at a hospital in the Bronx. I don't know the name of the hospital. After living in New York for a couple of years, two or three years, met my mom. They met on the East Coast. He was an intern in New York somewhere. Again, like I told you, I don't know the name of the hospital. She was a senior, maybe a senior, she was a student at Smith, and they had a mixer. And, of course, during the war years, a mixer in New

England didn't include a lot of Chinese-American students of either sex. So they met, fell in love, married.

Then they moved to--a very interesting history, but eventually settled in Honolulu. Now, they had a choice. This was very interesting. This is a kind of a total tangent here, but the nature of this topic, it's going to have a lot of tangents.

Mullan: That's good.

Ho: But they apparently were planning to go back to China to practice, where, again, my mother's family was well established in Beijing. And while he was third generation, born and raised in Honolulu, he came back after the war--

Mullan: Did he speak Mandarin?

Ho: No, but he could have learned it. And, of course, the Revolution was going on, and precluded them from going to China, to practice in China, or even in Hong Kong. It was still unstable. So by about 1948, '49, they decided to settle in Honolulu. So that's when his practice was started.

Mullan: Did your mom's family come out the other side of the Revolution all right, or what happened to them?

Ho: My mom's family is mixed. My mom's father and mother emigrated to Hong Kong, and my mom's two older brothers stayed in China, and her older sister and younger brother, along with her, emigrated to the States. So, it was different. And they had a choice, actually. My oldest uncle--I wish I could just answer "yes" or "no"--my oldest uncle, Uncle Arthur, stayed in Shanghai, where he was an engineer, and helped build a Shanghai industrial complex. My older uncle is a physician. Actually, he's still alive, and healthy,. I guess. He stayed in the northern part of China, a city called Darien, to practice, and then actually teach, became an assistant dean of the medical school in that part of the country.

They chose to stay because they were patriots. They weren't ideological Communists or non-Communists. They just wanted to stay and help build the motherland, which you find that, for some Chinese, is very common-- very few political aspirations, and lots of patriotic aspiration. So they stayed. But my oldest uncle, Arthur, didn't do so well because of all the repression in the fifties, and we don't know whatever happened, but he was a victim of a lot of persecution, and he died incarcerated, which happened to so many people. My older uncle stayed on, was victimized during the Cultural Revolution, but he survived and is retired now.

Mullan: A physician?

Ho: Yeah. I'm not in direct contact with him, just through my mother, just as of within the last year, she said he's doing fine. He's in his eighties, and retired, and kind of survived the turmoil of the last forty years.

Mullan: Have you thought about going to China ever?

Ho: I've been to China. I was there in '77, for a month, and I did get to meet my surviving uncle. This was right after the Cultural Revolution. He was relatively circumspect about the whole experience he went through, but, actually, was somewhat candid, talked about his persecution, and his puzzlement as to why Americans didn't ask more questions and read more than just American press. It was very interesting meeting him there. I spent the day with him in Beijing. I think there are lessons to be learned in China, but I think there are still more lessons here that could be hopefully better applied elsewhere.

Mullan: So your dad was a strong influence, in terms of both your medical interest and your youth in general, is that fair to say?

Ho: I never would have admitted it at the time. What rebellious child of the sixties would ever admit that? I think, in retrospect, my dad was a tremendous influence, one showing a real service and selfless orientation toward medicine, the noble part of the practice of medicine, and a certain degree of the

sacrifice involved. I think that was a positive role model. I think his general respect and sensitive love of people, I think were obviously very apparent as well.

In terms of general role model, I don't know if he was so much of a general role model. I mean, it wasn't conscious, let's say. This is only in retrospect. At the time, I don't think I saw too many virtues in my dad. He was very strict. He was outwardly not demonstrably supportive of his children, particularly of me. [Laughter] Other than baseball. I mean, it's like that scene in Billy Crystal, in *City Slickers*, when he says, "Well, the only thing you can talk about with your--" or *Field of Dreams*, the same kind of theme. The only thing you could talk about with your parents, at least with my father, was baseball. There weren't a lot of points of similarity, politically or culturally.

Mullan: What were you like growing up? You went to high school in Honolulu?

Ho: Yeah. Born and raised, went to high school in Honolulu.

Mullan: How did you find your way to Northwestern?

Ho: This was in the sixties, and we'll get to that in a second. I was very rebellious in high school, and very rebellious in junior high. I had three, if you will, negative role models, from my perspective. I have two older sisters, and a twin

brother, actually. I characterized all three, growing up, as "goody two shoes." I felt back then, and to a certain extent, I feel that now, they were very insulated, parochial individuals. And I grew up, for whatever reason, a true product of the society.

I remember being in junior high and getting very much involved with nuclear disarmament, and what I understood of the Civil Rights Movement on the mainland, the Selma and Washington, D.C., marches from '63 to '65. I was very much engrossed in that, very active, very active in organizing and participating in anti-Vietnam War issues in the mid-sixties.

And so when I went to Northwestern, it was very interesting, because I went to Northwestern and I didn't know much about the geography. Back then,, if you're going to go to college, from Hawaii, you either went to colleges on the West Coast or the East Coast. You went to colleges in the Ivy League schools or any number of colleges and universities on the West Coast. So, I needed to do something different, and I did two things by going to school at Northwestern. I wanted to not be in the mode of going to schools on either coast, and I wanted to be close to Chicago. I wanted to be close to an urban experience in the sixties. I just thought that was more important to be near that kind of energy, social change, and diversity that I thought would be missing in most other campuses.

So that's the kind of person I was then. Of course, being in Chicago in 1968 was a life-changing experience for many people, not just myself. And there are, I'm sure, dozens of

people you've talked to in this fact-finding who got the feeling of urgency and intolerance for the status quo, urgency to change the status quo and the intolerance for acceptance of that, and figuring how you could make an impact, making the world better for all of humanity. So that's how it brought me to Chicago, feeling that that was a platform from which I could grow.

Mullan: Were you active in anti-war activities or student activities?

Ho: In Chicago, yeah, I remained active throughout college, initially through SDS [Students for a Democratic Society] activities, and then after that, really the last couple years in college, from the seventies on, really involving myself in inner-city activities, really off campus, and helping to start free health clinics, if you remember that whole period of tutoring minority children, or helping Black Panthers serve hot breakfasts to impoverished children. Now it sounds kind of quaint, actually. But back then it was--

Mullan: Now it's called community service.

Ho: Yeah. So, I did a lot of that. So, was I active? Yeah, I was active, and I think what happened was what you just observed. I think my campus activism was very consciously channeled into community activism. I felt that was really a place where I could

make more of a difference. And actually, to tell you the truth, when I went to college, I had no intention of being a physician.

Mullan: What did you major in?

Ho: I majored in sociology and actually minored in history, nothing to do with science as a background. I wanted to be a teacher. I wanted to figure out ways of teaching about alternative ideologies and philosophies. Working as a teacher, I thought I could be a change agent. I thought that was a way I could be a change agent for improving society.

Mullan: What happened?

Ho: This is very interesting. I thought this was where I would start this discussion, but, you, with all your skills, got me talking about growing up in Hawaii. But what happened was, truly, and this may be corny, and it seemed trite, but there was a kind of a cathartic experience. A month before I started my junior year, and as I'd gone through my freshman and sophomore years, very much involved with campus activism, and anti-war activities, about a month before, maybe a few weeks before I started my junior year, I was in Chicago with a bunch of friends. You know Chicago at all?

Mullan: I went to University of Chicago.

Ho: Okay, so this is on the North Side. This is in Rogers Park. This is the closest Chicago urban--

Mullan: I left Chicago in '68. I was there '64 to '68.

Ho: So you know the whole thing.

Mullan: Martin Luther King [Jr.] was marching.

Ho: Yeah, exactly. So this was kind of a defining moment. About three or four weeks before school was supposed to start in September of--it must have been 1970, we were with some friends, at that time my girlfriend, but soon to become my first wife, and we were socializing with friends. We were walking back from a rainy night in Chicago, and as we left the coffee shop to where we were going, a whole bunch of us were going to a friend's house, and we saw on the sidewalk blood, lots of blood, a trail of blood, on the sidewalk, in the pouring rain. I really was very curious and concerned, where was this leading to? We saw this trail of blood, it went up this stairway, then a walk-up, kind of a tenement walk-up, and there was guy, halfway up the stairs. My friends went on. They said, "Okay, well, somebody's up the stairs, and let's not get involved. Let's keep walking."

So my girlfriend at the time and I, we followed the blood up the stairs, saw this guy, and he was bleeding from a pretty big gash on the back of his head. I said, "Well, do you need help?"

He said, "No, leave me alone. Leave me alone." He was drunk. "Leave me alone. I don't need any help."

I said, "Oh, we'd better get you cleaned up."

So anyway, to make a long story short, I helped him up to his room, cleaned off his wound, called the ambulance, and got him going to the hospital, where he was okay, but while I was there, he kept--he had this self-esteem issue. He said, "Don't bother me. Nobody wants to help a drunk. You don't need to help me." It was really kind of a moving experience.

So we went back and met my friends, and we were hanging out in the living room, just sitting there, the pouring rain, and I was thinking--and this whole thing took probably a couple of hours, with him, waiting for an ambulance, and so on and so forth. I was sitting there thinking. I said, "Well, this is how I should make an impact," and it really was a cathartic experience. This guy had no feeling of self-worth. I remember thinking consciously at the time--you know, I was all of whatever, nineteen, twenty years old--he couldn't afford medical care. "I need to be a doctor. I need to go into medicine so that I can make my impact in changing society and providing services to those who could ill afford it, or even if they could afford it, weren't educated to access it."

And for me, this was very radical. My last science class, I think, was taken as a junior in high school. I got a D. I wasn't a science-oriented kind of pre-med person. I was going to live a different life. So I said, "What would it take?" So I said that. I remember telling my friends, "I want to be a

doctor." And they laughed. They thought, "This guy's hallucinating. What's he smoking?" I said, "I'm going to be a doctor. I think this is where I can make the most impact."

So I didn't change my major, but I had to change my whole curriculum. I had to go back, take chemistry, biochem, organic chemistry, and physics, summer school, the whole thing. And I did that, I did all of that. In some ways I had a big advantage over other pre-med and medical school people, even, because I knew what I wanted to do. I knew why I was doing this. I've always felt strongly since then that motivation and a sense of responsibility, of commitment, is far more important than test scores or grade point average.

There is one small story there in that. So I decided to go into medicine, and one of the courses you have to take, as you recall, is organic chemistry. This was a bear to me. I mean, think about it. This guy's gone through high school with Ds in chemistry and physics, and gets to college, and all he studies are basic liberal arts classes, history, sociology, literature and art history, etc., and it's great, and then he has to take organic chemistry.

I'll never forget this, because my first test, we had these weekly quizzes, and you were allowed to drop your lowest grade. Because organic chemistry was probably so much rote memory, you had to keep up every week. To make a long story short, I got an F on my first quiz. I said, "Oh, this is it. This is the medical career. Forget it. You know, there's no way I'm going to get into medical school." But I basically buckled down, and I

got "A" on every quiz after that, and actually got commendations on the organic chemistry test. I mean, that was kind of my acid test. I convinced myself that if I could do organic chemistry, I could do almost anything.

Mullan: Before we go on with Tufts, going back again, your propensity for samaritanism and/or activism, where do you think that came from? What values were transmitted to you, and in what fashion, that got you going in that way? You mentioned church. Was that an important factor?

Ho: No. That was a social activity. I don't know. Because, you know, you look at my siblings. They never were activists in anything, church or politics or volunteerism, or anything like that. I don't know. Partly it might be my parents, I would have to say, and partly it was really the environment, the society we grew up in. My parents were both apolitical. They were both good people, but they didn't do any extraordinary amount of volunteerism, a little church activity here and there. They were both Christmas and Easter Christians. I mean, they didn't go to church regularly. It would be a nice story to say I had this role model, you know, the reverend in the church, or my mom doing bake sales every Sunday. They were very basic, good, decent, apolitical people, with no extraordinary effort or contribution to society, to tell you the truth. So that's good. The decency is important, because they taught me some kind of value system of right and wrong, but nothing extraordinary.

Mullan: How about your Chinese-American identity, or Chinese identity? Did that play a big role?

Ho: No, bing Chinese-American had nothing to do with my initial activism because growing up in Hawaii, it's a pluralistic society. I never felt myself as a minority.

Mullan: When you came to the mainland, did that change at all?

Ho: Yeah, yeah. Yeah, but that was also in the sixties, so whatever it would have changed would have been fomented by ethnicity and national pride. Not to put it down. I think I learned a lot about looking at Hawaii from the outside in, as a relatively colonial experience. I think I learned something in consciousness there. The fact that the Vietnam War included, in my opinion, an invasion and a subjugation of an Asian country, I think that had something to do with it. I think my experiences in Chicago, then later my experiences in Boston, really helped identify my role as a minority in American society. I don't know if that was the decisive factor in making a change. I didn't go into medicine or doing anything that I've done as a minority, I think more, again, as a social agent, as an agent to help better society, or, right now, better health care delivery in this country.

Mullan: Let's move on to medical school then. How did you pick Tufts, and what was it like going to Boston? Finally got to the East Coast.

Ho: I finally got to the East Coast. I had married by then, and we basically chose a few cities where we both could pursue our graduate school work. She was in educational policy, and I wanted to go into not just medical school, I wanted to go into family practice. I knew when I went to pre-med, I said, "I'm not just going to medical school. I want to be a family physician for the inner city." I mean, that was how focused I was.

So I looked around, and we chose, I think it was, four cities. Yeah, it was just four cities that we could both have compatible graduate school experiences in her field and my field. They were Los Angeles, Chicago, New York, and Boston, that would have some family practice program that would be reasonable for me to pursue, and some graduate program in educational policy, which was her field, and still is her field, that she could pursue.

We did get accepted in schools in same cities, but to be perfectly frank, we got our most financial assistance from the schools in Boston--her at Harvard, and me at Tufts. That's how we chose. In fact, I had gotten into Boston University and Tufts, but Tufts had a better financial package for me. That's the only reason. And it turns out I'm happy with it, because I had a very good opportunity for me to tailor a primary care curriculum there.

Mullan: How was Tufts?

Ho: Tufts was very good. Tufts, first of all, allowed me to tailor, because being in Boston, they didn't know much about primary care, much less family practice, but they allowed me to tailor a fairly customized elective curriculum my junior and senior year. I worked extensively in a Boston Chinatown free clinic, the medical clinic. So it helped me pursue all the activities I was still involved with in Chicago, which was kind of free clinics, social medicine, community service, and a curriculum that actually, in retrospect, was excellent for family practice. I designed my own rotations in outpatient orthopedics, outpatient ophthalmology, and so on and so forth, so it was excellent.

Mullan: How was immersion in the medical environment after your basically liberal arts background up to then? Did you find medical school tough, tougher than some of your colleagues who were biochem majors?

Ho: You know, I was so motivated to success. That's kind of one of my characteristics, is tenacity and absolute motivation. I didn't get into Alpha Omega Alpha, but I did well, in fact, very well in my clinical rotation, much better than I did on my basic sciences, and that would be consistent with how I apply my learning. This could have some real-world impact.

Mullan: So how did you break yourself through and out of Boston as a family practitioner? You tailored the courses. Did people look down on you for it?

Ho: Oh, yeah, but that didn't matter. See, I had such presence of mind, or presence of myself that, yeah, even in Boston, I was especially determined. In the Boston academic medical community of the 1970s, if you were going into primary care, especially if you were going into family practice, and you had any semblance of professional potential, you were actively dissuaded. I mean, every rotation I was in, whether it was a surgical rotation, or a medical, or a pediatrics rotation, I was actively dissuaded not to go into family practice. But I really knew what I wanted.

For me, at that time, in order to make the most impact in serving more of the medical needs of the inner city population, I needed to go into family practice. So in OB/GYN, attendings said I had to go into OB/GYN. In internal medicine, they said I had to not just go into internal medicine, but I had to sub-specialize into cardiology, infectious diseases, rheumatology, pulmonology, whatever it was. But it didn't alter me at all. In fact, it reaffirmed my commitment even further, because I said, "Well, that's exactly why I have to go into family practice, because specialists are a dime a dozen and not focused on the needs of the urban poor coming out of the Boston factories, so I need to do something different."

Mullan: So you, at the end of it, decided to come back West?

Ho: Yes, because my wife's family was in Oregon, and my family, of course, was in Hawaii. One more point. We were in Boston during the Boston busing episodes from '72 to '76, and that was very disturbing.

Mullan: The south Boston school blow-up?

Ho: Yeah. They had beatings and they had mobs. That was very disturbing, because we had friends--we were an interracial couple. My first wife was Caucasian, and we had a lot of friends of every ethnic background in Boston, and they were all affected--white, black, Latino, Asian. And so anyway, there was some personal discomfort of being there, so we really wanted to move West, where the climate was a little more tolerant and it was closer to our families.

So, again, same thing. What city would be best for us, and which residency would be best for me? We were lucky enough to be able to go to San Francisco, although we didn't have any direct family there. It was close enough to Oregon and Hawaii, and a city that was great. The San Francisco experience was so good, we stayed there, and lived there sixteen years. It gave me a chance to do social medicine in residency.

Mullan: Was family medicine, when you got there, what you hoped it would be?

Ho: Good question. Yeah, I would say so. I had some problems with the curriculum at the family practice residency program. I think it was more behaviorally oriented than socially oriented. I think it could have done more to give residents and medical students more of an experience in the community environment instead of just practicing family therapy on inner-city families. But, in general, yeah, the curriculum at San Francisco General, just being at San Francisco General was excellent. So I was pleased with that. I was really happy to be training at the county hospital, dealing with the people that I wanted to eventually be more committed to. It was, I think, very enjoyable.

Mullan: What were your plans as you--

Ho: Again, I was also thinking, consciously, how I can do the most service and make the most impact in the inner-city population. So my plan after that was to set up a clinic, a multidisciplinary clinic, in the inner city of San Francisco. And that's where I got into contact with the National Health Service Corps, because while I was in residency, I helped develop a feasibility study, ironic as it may seem, to see if there were health manpower shortage areas in the urban area of San Francisco. We went through the whole application process and feasibility designation process, and were able to get a National Health Service Corps designation at a site in the Visitation Valley neighborhood of San Francisco..

Mullan: This was in San Francisco?

Ho: In San Francisco. It was in a ghetto, an underserved area of San Francisco, which is fascinating, because many San Franciscans don't even know this neighborhood exists.

Mullan: It's called Visitation?

Ho: It's called Visitation Valley. It's in the southernmost central section of San Francisco, and the reason it's kind of unknown, on its eastern border is a freeway and Hunter's Point, which is a very large black neighborhood, and to its west and north is a mountain ridge that separates it, so it's this little enclave with about 15,000 people, didn't have any physicians, demographically mixed. At that time, it was about 40 percent black, 40 percent, Italian immigrant, and 20 percent Asian. So it was great. I mean, I didn't even know it existed. We were looking for shortage areas, manpower shortage areas, that would qualify in San Francisco.

Mullan: And you found one.

Ho: And we found one, and we built this clinic. That was in '80. Then something very interesting occurred.

Mullan: Was that the San Francisco Family Health Program?

Ho: Yeah, right. So we set up a not-for-profit, 501(c)(3), so we could qualify for low-interest loans from the government, and we became National Health Service Corp site. My partner was African-American, and we didn't have National Health Service Corps scholarships going through medical school, but we had, I think--I forget the name of it--health profession loans . So we had to go through the Washington--

Mullan: You got a loan repayment?

Ho: Yeah. So we had to go through the Washington bureaucracy to figure out if what we did for the National Health Service Corps could qualify as a loan repayment for the other professional loans that we had gotten, and they did. It was kind of circuitous.

Mullan: Were you actually in the National Health Service Corps? Were you salaried by them?

Ho: Yes.

Mullan: So you were actually in the Corps?

Ho: No, actually on the civilian side.

Mullan: From '81 to '83?

Ho: Yeah, '81 to '83.

Mullan: And at the same time, you were also doing emergency work?

Ho: Right. Just moonlighting on weekends. Getting the practice going. Actually, what happened '81 to '83 also was I was teaching, because we were trying to set up a community-based residency program, so up to then, the family practice residency program was based at San Francisco General. Of course, we had the Ivory Tower institutions at Moffett Hospital and others, but we didn't have a community hospital experience. And since I was on staff at St. Luke's, I said, "Well, let's just see if we can develop a component of the residency program at St. Luke's."

So this is where I began to develop a more eclectic professional experience. I said, "Well, I'm practicing. I'm really enjoying it, doing Marcus Welby medicine." You know, doing obstetrics, abortions, house calls, hospice care. You know, doing it all, loving it. I loved practice. I said, "But there's something more here that we need to do. We need to teach this, because they're not learning this in San Francisco General, much less the academic medical center. They're not learning comprehensive family practice." So I said, "Let's start looking at that."

Because it's one thing to do this really very comprehensive medical practice with 2,000 patients, but if you're able to teach it, then you can have a multiplier effect in terms of impacting

people. And also, simultaneously, I was involved with bringing the first HMO contract to St. Luke's. which was a Medicaid contract through a not-for-profit HMO that was based in the East Bay, called Rockridge Health Plan. I said, "Let's bring that in." Since 50 percent of my practice was Medi-cal anyway, I said, "Well, let's bring in the Medi-cal, and do it on a prepaid basis." That way I could expand my Medi-cal base, and provide more preventive services, and we'd be at a community hospital. Simple. Of course, there was tremendous political backlash. At the same time, this whole period--'81 to '83--for me, as a pariah, almost, because I was bringing an HMO contract, and I was bringing in a residency program which aggravated the town/gown conflict.

So here I was, between '81 and '83, I loved it. I thought it was just fascinating, juggling these three balls. I'm doing public service, and practicing medicine, trying to start a teaching program, which we succeeded in doing, and trying to bring in an HMO contract, which we succeeded in doing.

Mullan: This was all at San Francisco Family Health Programs, at 141 Leland Avenue?

Ho: Yeah, yeah. So it really was a crucible of chance. Fascinating. It was really exciting for me to be in this crucible of change, because that was kind of what I wanted to do. Make change resolving conflict.

Mullan: And what was the view of the HMO as a concept back then? Who was fighting it and who was for it?

Ho: In '81 to '83, the people who were for it were really nobody, really, except for state policy. There weren't too many takers. I was for it, in the sense that we would be accountable for the health of a population, that we could really be accountable for the preventive services, health education, diagnosis and treatment. So I liked it, because it was a prepayment system that reflected public health goals.

Mullan: And was your population prepared to sign up?

Ho: Yeah. A few thousand signed up.

Mullan: So you enrolled the people you already had as Medi-cal patients?

Ho: Yeah, and we got new patients, too.

Mullan: It was a capitated arrangement?

Ho: It was capitated. So I think the proponents were basically--let's see, who would be the proponents? State policy-makers, a few relatively progressive-thinking family practitioners. We had six of us on the panel. I mean, it was

small. And the patients liked it because they could get more benefits on a prepaid basis.

Mullan: So it was different. You mentioned you had one partner in the practice.

Ho: Right. Then we affiliated with four other family docs.

Mullan: For the purpose of the Medicaid/Medi-cal HMO?

Ho: Right.

Mullan: Who were in the same general area?

Ho: No, throughout the city, actually, and not necessarily inner-city-focused, but they saw it as a revenue stream. So they were relatively progressive, given the mainstream.

The people against it was everybody. Hospital administration was neutral, since it reflected a potentially expanded revenue source, but all the medical staff was absolutely against it, because it was basically stealing their patients. And there was some kind of conspiracy theory, because they felt this connection between the HMO and the medical school. So here he wa--me, Sam was bringing in a residency program and an HMO contract, same year. So I really was very unpopular on that medical staff. But it was okay, because I brought a lot of admissions to that hospital.

Mullan: At St. Luke's?

Ho: Yeah. I think I was there before Tom got there, actually.

Mullan: So what happened next?

Ho: To make a long story short, I'm just going to fast forward. So I'm really loving practice of medicine. I really enjoyed it. It's just a great, exhilarating experience, because I really thought I was making an impact. But I also saw increasing need for more of a policy approach, that the more you make an impact, that same kind of concept, the constant theme through my career, "I'm making an impact on 2,000 people, but I can make an impact on 20,000 people indirectly through policy. It may be less directly rewarding, in terms of the "thank yous" and the tamales at Christmas, but more of a long-lasting systemic approach to making social change." I felt really much more fascinated with policy.

I got increasingly involved in the HMO side, still kept about a 20-30 percent with teaching, until about '86. In 1986, Rockridge had been acquired by a plan called HealthAmerica, and HealthAmerica got acquired by a plan by Maxicare. So this is all in the mid eighties.

Mullan: And your practice remained at--

Ho: Inner city and Visitation Valley.

Mullan: But you got more involved with Rockridge, in terms of their operation?

Ho: Right. Rockridge, and then HealthAmerica. Yeah, I just got more involved with policy. The systems we had developed on Leland Avenue and Visitation Valley were good systems, and National Health Service Corps helped a lot. Good systems related to preventive services, good systems related to health education, good systems with health fairs, good systems related to use of nurse practitioners. And so I figured, "Well, I should be able to extrapolate these systems." .

You know, we did a lot with the community. I even won an award. In 1985, the San Francisco Foundation, which was at that time, the largest philanthropic foundation in the city of San Francisco, for some coincidental reason chose Visitation Valley as a target neighborhood for 1985. They investigated and talked to all the community representatives and the leaders and the senior centers and everything, and said, "Who's done the most with the least?" So I got this award for being this family practitioner, the Marcus Welby of Visitation Valley. That wasn't the name of the award. The award was something else. The Daniel Koshland Civic Unity Award.

Because of that kind of award and that kind of recognition, I said, "I should nourish that. I should teach these systems to other people." Beautiful award. It was really great. So I got more and more involved with policy. I said, "If we can make it work here, we can make it work anywhere." That's the same

National Health Service Corps idealism--that we can really change the world. And I still believe that, by the way.

Mullan: But there must have also been a sense--I mean, as you describe your work, your ability to deal with the finances and the business side of making a practice work seems to be bubbling up.

Ho: I like administration. I like the administration aspects, I like the teaching aspects, and I like the practice.

Mullan: It strikes me as more than administration. In the early mid-eighties when nobody knew much about prepayment or capitation or population medicine--if it did, it was sort of hypothetical, you know, epidemiologists talking about population medicine, but it strikes me that you were linking some population science concepts to some fiscal accountability concepts, which were the seeds of something very different.

Ho: Right. I would agree with that.

Mullan: With a propensity for being able to handle both sides of that.

Ho: Right. Yeah, I think you're right. I saw a college classmate of mine about two months ago. This is an aside, but

it's interesting. She said, "Do you remember that paper you wrote in 1971?"

I said, "What paper?"

"The paper that you lent to me that I was able to parlay into three different courses with A's."

I said, "No, I don't know anything about it. What is it about?" I honestly have no recollection of the topic, the content, or anything else. The paper was written in 1971, apparently authored by myself--I have no idea--written about universal health care coverage, and that in order to finance this--I mean, I had no idea I could even think of these thoughts back in 1971--but in order to have universal coverage for everyone, that we have to finance it with a prepayment system of some sort that would be able to amortize costs across the entire population. I had no idea about that, and I don't even remember it. I wouldn't have remembered in '81--

[Begin Tape 1, Side 2]

Mullan: This is Dr. Ho, tape one, side two, continued.

So the paper, you don't remember at all?

Ho: I don't remember anything about the paper. She just told me that two months ago. And in the early eighties, actually, when I was doing all this, this conscious effort to go into prepayment, take risk, so that we could provide better population-based service, I would agree, there was an attraction there. There was

a challenge there. I liked the idea. And there was a societal implication there, as well. I was attracted to that.

And so by '86, it became clear that I couldn't do all things. I couldn't continue juggling these balls effectively. I couldn't continue practicing medicine, and teaching, and administering programs. I just felt it couldn't be done. I couldn't do a service to any of them very well, and particularly seeing patients. I was like the role model of my dad. People would call seven days a week. The practice up to '86 that I was doing, which was obstetrics and hospice care and AIDS terminal care and abortions, and doing it all, I couldn't any longer do it all. I couldn't. There weren't enough hours in the day. I felt, at that time, it wasn't fair to the patients.

So I gave up both teaching and practicing medicine, so that I could focus on HMO administrative work.

Mullan: That's when you became the medical director of Health America, or Maxicare?

Ho: Right, yeah. I said, "Well, I've got to do that." I felt I could make more of a contribution because I think my skills were more unique in that field.

Mullan: And what were you seeing then? Because you could have pursued administration as a hospital administrator, as a medical school administrator, department chairman. But you chose a

particular kind of administration which at the time was not vogue.

Ho: Oh, absolutely the opposite. It was not a status kind of area.

Mullan: But what were you seeing? What did you sense yourself, and what did you foresee?

Ho: I felt then, in 1986, I felt that HMOs were absolutely the future, because it was accountable for costs, addressed health from a total population perspective, and integrated and financial systems. Health America/Maxicare was still Medicaid. This was all still a large Medi-cal population. In fact, it was predominantly Medi-cal. But this was a way of providing more good to more people, more services, health education, preventive services, to a certain extent, social services, to people who needed care. Prepayment was a way of giving a comprehensive health benefit--not so much a medical benefit--a comprehensive health benefit to underserved populations.

So that was a conscious effort. In fact, the conscious thing, to me, was you can have a lot of individual success stories that wouldn't make an impact on society. You could have a lot of Marcus Welbys. It's still not going to make a systemic change. You can have a lot of good teachers, which is good. We need good teachers in medicine and social medicine. But I still don't think that was a way of change. I still don't. I still

think that the best way to institutionalize change in this country--this is my bias--is through the private sector, whether it's not-for-profit, or for-profit, but in the private sector, in the marketplace, innovating and creating new programs to meet ever-expanding new needs.

Mullan: There is, and always has been, a side of managed care in general, but certainly Medicaid managed care, at least the arguments particularly in that epoch used against it were that it was a cheap way to kind of herd patients into substandard care, and, as I recall, there were fairly rigid rules from HCFA that, in a Medicaid practice, you could only have so-and-so many Medicaid if you didn't have commercial patients. This was sort of to prevent a kind of herding.

Ho: The Medicaid mill kind of approach.

Mullan: What did you see? Was that an apt concern?

Ho: Yeah, I think that was an apt concern. There was a plan in California which preceded me, actually, in the mid-seventies. I think it was called the American Health Plan, which turned into a Medi-cal mill. It was an apt concern with policy-makers. I think it was really good for HCFA and others to put in those safeguards.

From my point of view, I was beginning to understand--you know, I didn't have an MPH, I didn't have any formal training in

public health, but I began to understand two things. I remember this in '86. I'll tell you why, and give you an example. I began to understand epidemiology, the study of population health and population disease, that, intuitively, blacks were having worse outcomes in obstetrics. They had worse outcomes. They had more pre-term deliveries than anybody else. This is a way of approaching those problems from a systems-oriented perspective, so that all blacks identified could get prenatal education and prenatal care.

But I also began to get an understanding of what has since been termed "clinical epidemiology," the variability in the practice of medicine. And gosh, we should do better at eliminating the variability. For example, I remember, back in '86, '87, developing a management grid that looked at the referral patterns of different physicians, and some physicians had a four- or fivefold--and this is shocking to me--variability in referral to physical therapy for the same patient population. It's age-adjusted--I don't think I did sex-adjusted--it's in age-adjusted referrals for patients to do various outpatient procedures. My partner, my African-American partner, had a fivefold rate of referrals to orthopedists and to physical therapists, than myself. And I'm not saying mine was the best. I'm just saying, "Let's try and make this standardized." I didn't know any of these terms then, I remember. "Let's try and develop some kind of standard," which was a benchmark--I didn't know that term then--that we could work off of, so that we could

have some more consistent expectations of utilization and quality outcome.

This was all fascinating to me. I liked that. So I really got into that. It was just kind of, like you said, more than just administration, but really trying to understand, let's say, maybe a little sense of management, but really understand the differences in the practice of medicine and the differences in health outcomes, and to make a point of improving that.

Mullan: So that was what appealed. And what was it like as you kind of immersed yourself full time in HMOs' administration?

Ho: I really enjoyed it. I enjoyed it a lot.

Mullan: Did you find the culture very different? You're now dealing with managers and business people to a large degree.

Ho: Yeah, it was very different, but I was very comfortable in that environment. And also I was still on the medical side, as I still am. There have been a lot of MDs who've gone on to just do the straight administrative side. I always wanted to stay on the medical side, teaching or educating or working with physicians and non-physician health professionals to deliver better care.

I remember those decision points in my career in '81 or '83 or '86, at that time, still saying, "Where can I do the most good, given my skill sets? I'm not any renowned clinical researcher, although I know something about research. Or my

practice skills, again limited in the population that I would be serving 2,000 people. Given my skill sets, where can I make the most impact?" So I think I made those decisions consciously, so when you asked in '86, if I were going to full-time administration, that I had a choice of academia, or clinic administration, or whatever, why I would choose HMOs. I think I felt like that's where my skill sets would afford me the ability to make the most impact.

Mullan: But you also had a dalliance with public health. You went back and flirted with public health. Tell me about that.

Ho: This was really great. This was a wonderful experience. It was, again, a conscious decision. So I finished the work at Maxicare, and this was before Maxicare declared Chapter 11 and reorganized. I was called by my old professor in family practice, who is Dr. Werdegan . Have you talked to Dave, or do you know who he is?

Mullan: I know Dave.

Ho: So Dave calls me, and he had at that time become health director for the city and county of San Francisco. And he calls, in his own very professorial, very inscrutable way, "Do you happen to know anybody, Sam? What we're lacking here in San Francisco's health department is a primary care system. Everything is categorically funded. You're very familiar with

that. And this lack of coordination for patients, we may be taking care of 100,000, but they're all disaggregated. They're getting care from child health and disability prevention funds, or they're getting care from WIC funds, or they're getting care from community mental health funds. We need somebody who can help organize our incredibly disparate system of categorically funded dedicated clinics into a primary care network. Do you happen to know anybody?"

I said, "No, I don't know anybody. But, you know, I'd be really interested in that job."

"It would mean leaving the private sector. You'd have to come back into the public sector."

I said, "This is great. This is the kind of challenge I want. This is wonderful." I'd come, and I'd set up a four-year plan.

So he recruited me. I set up a four-year plan to turn--which was a phenomenal smorgasbord of absolute disconnected delivery systems, administrative systems, funding systems into a cohesive primary care network. I said, "Good, let's do that." So I said, before I came over, I said, "Dave, being relatively politically naive about inner workings about city and county government, I just need some assurance that there be some authority here to make some changes, because obviously I don't know what all the changes are going to be, but there are going to be lots of changes, and I need your support and the support of any other authorities."

"You have my support. I don't know what it's going to take." Dave said that, too. "I don't know what it's going to take, but you have my support."

So I said, "Okay, let's do it. Let's try this experiment. Can we turn a completely entrenched bureaucracy into a relatively well-integrated primary care network where you have all these various neighborhood clinics working together?" They had all different medical records. Some didn't have medical records at all. Some of them had five-by-eight cards. You know this. This was public health. It was a mess.

So it was really exciting. I was able to say, "Let me take what I've learned in the private sector, in terms of systems development, and apply it." I gave myself four years. I accomplished everything in three years, and I was really proud of that. But I was also never what we'd call a "lifer." I was never going to stay there, because there was always going to be something bigger to build.

Mullan: Did that happen that easily? What was the state of the clinics when you actually got them put together? Were you able to develop primary care systems for them?

Ho: Yeah. We developed common systems: quality assurance systems, utilization system, medical records system. They had an information and billing system. Never happened before. Kind of a PC-based system. Financial system, to be able to collect--I

mean, not a lot of money, but more money than they ever collected before, several million dollars.

Mullan: Eight million dollars.

Ho: Oh, is that what it was? Yeah, it was several million.

Mullan: What's a million, one way or the other? [Laughter]

Ho: I was very proud of my accomplishments. I couldn't have done it by myself, but I also know that it couldn't have been done without me. It was one of those things that at one point, I think I had something like twenty-five or thirty direct reports, as well as physicians in rebellion. Who'd want it?

But again, the same thing--keeping focused. It's like going to medical school, or taking organic chemistry. I kept thinking, "What's the end game here? We've developed a system that could be prepared to go into a risk contracting agreement in 1991 for the state of California, then that would be worth it." And it did. So there's some legacy there.

Mullan: So that was the '89 to '91.

Ho: '88 to '91.

Mullan: And you'd switched cultures back to the--

Ho: Yeah, back to the private sector. At that time I became firmly convinced that by '88, '89, while doing public health--and I love public health. I love facing huge problems like the AIDS epidemic and working for better approaches to that, or the substance abuse epidemic, or teenage pregnancies. I mean, I've really thrown myself into every position I've had. But I really became quite convinced that the ability to make an impact in this country, significant change in this country, is going to be at the system level, not on the individual level, and it was going to be in, at that point, I felt, in managed care. I'd had a taste of public health, I had a taste of academia, I had a taste of private practice, I've had a taste of managed care on the not-for-profit side, I had a taste of managed care on the for-profit side. So I had enough of an eclectic background to say that in order to make the most change quickest, it was going to be in the for-profit, private sector.

For example, at that time, in '91, I said it wasn't going to be Kaiser. I'd like it to be Kaiser, but it wasn't going to Kaiser at that time. So I consciously looked at a plan.

Mullan: Tell me a word about the for-profit/non-for-profit experience to date. Maxicare and--

Ho: Maxicare was for-profit. Health America was for-profit. Rockridge was not-for-profit.

Mullan: I don't know whether this is a pertinent question, then as opposed to now, but the for-profit/not-for-profit worlds, cultures, *modus operandi*, quality of people, are they substantially different?

Ho: Oh, wow. Great question. At that time, no. At that time, '91, in California, the only difference between the for-profit culture and the not-for-profit culture, in my opinion, was access to capital. The mentality at Health Net, at that time, not necessarily the Health Net now, but the Health Net in '91 was really focused on population-based health improvement, wellness.

If you've seen the billboard--it's right here in LAX. It says, "California's Health Plan." It's the Wellness Company. It was the first HMO, at that time, to really promulgate and really extol the virtues of wellness. Preventive medicine, preventive health, was emphasized by other for-profit companies. FHP, at that time, '91, founded by Dr. Robert Gambiner, was focused on cost-effective health care. Pacific Care, where I am now, was always talking about better member services, and how to make members happier and healthier. It's really changed dramatically in the last five years, but at that time, why I wanted to look at for-profit companies which had access to capital was that they had that drive for entrepreneurial innovation, and I didn't see that in Kaiser.

I saw in Kaiser, basically, a private sector health department back in '91. I said, "Well, that change would take too slowly." Because these for-profits had commitments to

capital markets and commitments to shareholders, forced them to innovate. So I saw the good aspects, if you will, of the American definition of the assets of entrepreneurial systems at work.

Actually, parenthetically, Health Net had been trying to recruit me since about six months into my public health job, but I had this commitment, and I really had this mission. I politely deferred, and said, "Go along with your ways, and if, when my job is finished here at the health department, you still have an opening, I'd be more than willing to discuss that."

So, in fact, that's what happened. When it was clear that my objectives were going to be met in the health department, Health Net was still in contact with me, and I gladly and willingly joined Health Net, to figure out a better way of privatizing public health objectives. It was very conscious, I remember in 1991, in terms of drawing up a pro and con list that everybody invariably does when they change careers, and I felt that was the greatest place where I could make the most impact.

Mullan: Was M_____ at Health Net at that point?

Ho: Not yet, no. Absolutely not.

Mullan: The pedigree of Health Net was--

Ho: Roger Greaves, who came from Blue Cross Southern California. I'll get into that, but let me backtrack one more point. One

overriding philosophical paradigm that I had set up for myself back in the early eighties, in terms of any job I would pursue, was that I always weighed two aspects, my ability to make an impact--and this is conscious, back in '83, I remember thinking, "What's my ability to make an impact weighed against the degree of constraint?" Those are always the two things. They're still the operative way I've framed my employment choices, throughout my entire career. My ability to make an impact--

Mullan: Versus operative constraint.

Ho: Could be operative, could be philosophical, could be strategic, versus degree of constraint. So the public sector, my ability to make an impact was obviously great, but at some point, as diminishing returns--at least I felt that there were overriding degrees of constraint. In fact, every time I've ever changed jobs in the past, which is pretty frequent, as you can see in my résumé, it's that the degrees of constraint overwhelm the ability to make an impact. Because I think in every job I've had, I've demonstrated an ability to make an impact, but the degrees of constraint, at different points in time, whether it's budgetary or philosophical--which we'll talk about with Health Net--strategic, operational, whatever the reasons are, there can be some overwhelming imbalance in that diad.

So I went to Health Net when Roger Greaves was the CEO. It had pretty much a non-profit board. It started as a not-for-

profit. It had just converted to be for-profit within six months before I arrived.

Mullan: From being Blue Shield?

Ho: It was Blue Cross. Blue Cross and Blue Shield are separate in California. Blue Cross of Southern California developed Health Net as an HMO in the late seventies. Parenthetically, Blue Cross of Northern California developed a plan called Take Care in the early eighties. Health Net, for Blue Cross of Southern California, became relatively successful by 1986, then basically divorced itself, led by Roger Greaves, who was its first chairman and its president, away from Blue Cross of Southern California. They became competitors. Blue Cross of Southern California would then have to develop its own--

Mullan: Did it go through the phase where it had to set up a foundation, or put its assets--

Ho: Yeah, right, right.

Mullan: --which created Wellness Foundation?

Ho: Yeah. California Wellness Foundation.

Mullan: So that was where that came from. I'm trying to get this history down.

Ho: Yeah, so the history for Health Net was, it started off as a subsidiary of Blue Cross of Southern California in 1979. By 1986, it split. It was still not-for-profit. It split off from Blue Cross of Southern California in 1986. It went for-profit in 1991, February. In February '91, it formed the California Wellness Foundation as part of a deal, and I joined in summer, July or August, of '91. So I just came on.

So it still had a not-for-profit mentality, but it had the for-profit entrepreneurial drive for innovation. And its board was still kind of not-for-profit type of National Health Service Corps, community-focused kind of a board make-up, which I found very, very attractive. So here was a company that was showing the further evolution of my personal ideals and ambitions, that, yes, I still wanted to make a change, but I wanted to make effective change, and I wanted to have enough spirit or innovation and resources to back it up.

Mullan: So what did they recruit you to do? What was your initial job?

Ho: My initial job was Northern California medical director. Unlike the Maxicare-Health America experience, this did not have a significant Medi-cal component. So this was my first extensive venture into the commercial, employed population. You know, they have this kind of funny thing. I felt that being in public health, in San Francisco's Health Department, and being with a Medi-cal population, this systemic issue had to go beyond Medi-

cal. The whole system was screwed up, basically. Didn't focus on preventive care, didn't align its incentives right, didn't give doctors the measurement or the data tools that they needed to practice better medicine. So I really felt that we needed to make change.

So Health Net at that time had several hundred thousand members, and soon to be a million members. "I can make the change here." So I started working in the region of Northern California, actually only a year, only '91 to '92. Then at that time, Health Net wanted me to come to Southern California, in '92, to reorganize all of the medical operations, because I was showing this proclivity or propensity for administration. I like to change systems and make things more efficient, and hopefully help doctors practice better medicine. So, in '92, I moved.

Mullan: Emeryville?

Ho: It's next to Berkeley, between Berkeley and Oakland. So what started off as a Northern California-focused job very quickly, within nine months, accelerated. They said, "Well, we need help. We have a medical director down here, but he's not operationally inclined. Doesn't know enough about systems. He's just a good guy. Can you come and help him?" So I came down. I said, "Yeah, I'll come. I'll help him." I was separated from my wife at the time. I was ready for more and bigger and better things. And I realized, at least in California, that in order to

make change, that the center of HMOs in this state is in Southern California.

Mullan: Why is that?

Ho: Well, for a lot of reasons, I guess. The headquarters of a lot of companies are there. Pacific Care's headquarters are there, Health Net's headquarters, Blue Cross. Blue Cross of Southern and Northern California merged in the mid-eighties. So Blue Cross of California, FHP. A lot of HMOs' headquarters are here. And also, you have a much more mature, as you've learned since then, we've all learned, that it's a much more mature managed care market. More evolved health plans, more evolved purchasers, more evolved medical groups.

So I said, "Yeah, I'll come down." And within a few months, the medical director retired, and they offered me the position of taking the medical director. And also, within a few months after that, the head provider services person at Health Net retired. So it's all kind of coincidental. So the medical director retired, and I was promoted to his position. The senior VP for health services, which included all the contracting, retired, and I've learned a lot about contracting in the last decade or so. So they replaced both of those positions with myself. And then Health Net merged with QualMed. So Health Net formed a merger with QualMed, led by Malik Hasan, who's a neurologist from Colorado--actually, from Pakistan, originally. And he announced the intent to merge with Roger Greaves at Health Net.

Mullan: He was QualMed to begin with? That was his space?

Ho: That's right. That was his space. And to make a long story short, there was a power struggle, and he won out. Actually, it wasn't much of a power struggle. Roger Greaves developed, in my opinion, philosophical alignment with Malik Hasan, which was diametrically opposed to my personal agenda. Their strategy didn't focus on improving population health.

Let me backtrack. All the reasons why I wanted to work at Health Net were quickly undermined by the merger: focus on population health; improving health status outcomes; looking at physicians as partners in that health delivery equation; focusing on quality improvement. All of those issues became secondary to driving down costs, adversarially relating to physicians, and building shareholder value as a primary focus for a business strategy. Now, I'm not against shareholder value. I've made that point very clear, in terms of access to market and entrepreneurial innovation, but I feel that if you do a good job at quality improvement, working well with physicians, focus on population health, shareholder value--when you do that efficiently-- shareholder value will be an absolute and undeniable consequence of those primary business objectives. So I decided to leave.

Mullan: Will you tell me just a bit more, before we pursue you, so I understand better, was this Hasan's philosophy, or was it in the nature of the--

Ho: It was Hasan's philosophy, which Roger, in my opinion, embraced.

Mullan: Roger is a physician?

Ho: Roger Greaves is not a physician. How can I say? Let's just say there are two legitimate business philosophies which you'll see in every business--computers, electronics, banking, airlines, or any kind of big business, manufacturing. And the business philosophies are both profitable, they've both been proven successful. You can go into any major industry and see the different contrasts. But one business philosophy says, "We can really be the low-cost producer, drive cost and fat out of the system, do it by any means necessary, and you will exact a relatively good return on investment." It's a short-term, cost-driven focus that breeds adversarial relationships among your vendors and your suppliers.

An equally successful alternative would be, "Yeah, we have to be really mindful of cost. The best way of doing that is investing in the future, building up collaborative relationships with your vendors and suppliers. Focus on values--human and societal values. And, yes, in fact, you will return good investment to your shareholder." And I think Roger Greaves and Malik Hasan developed, over the course of a year, extreme alignments on the former. I think they both saw this as really good, and it's not, quite frankly, disputable. There are successful models for that business philosophy.

When I left Health Net, I left because I had a difference in business philosophy. I'm not saying one is right, or one is wrong, but one was right for me. I don't think Roger had that philosophy certainly when I joined Health Net, and I think he developed it as he--

Mullan: But he also lost out in the merger?

Ho: Right.

Mullan: So you made a decision that this was not--

Ho: Yeah. I said, "This is a successful business philosophy. I'm not here for a job. I'm here to try and make and impact on changing health care in this country." I'm still chasing that windmill.

Mullan: There are those, I gather, who disagree that the first strategy, the drive prices down by whatever means, in a human services industry, is destructive.

Ho: It's short-term. Yeah. Oh, I would argue, yeah, easily, between the two of us, and 90 percent of the people you've interviewed, I'm sure, for this book, I'm sure you can put the good arguments out there. Yeah, I think it's a short-term focus, and it presumes a relatively infinite tolerance on the part of providers to accept that type of strategy, and I don't think it's

a sustainable strategy. The point of that, though, is it's sustainable as long as we have excess capacity and wide regional variation in clinical and cost outcomes in this country.

In other words, from an investor point of view, hell, it'll be another twenty years before the excess capacity is rationalized, so let's ride that pony for twenty more years. So I still think it's a sustainable medium-term strategy, and in twenty years, Malik Hasan and others will be retired. So I think there's some logic to it. For example, you still have excess capacity of somewhere up to 1,000,000 hospital beds in this country, or up to 200,000 specialists, and financial variance that ranges, in some cases, five-, sixfold. Commercial bed days, between 130 to 400, depending on what part of the country you're in. So as long as you have that, that philosophy will have an opportunity.

Mullan: Quite interesting. Well worth pursuing, but let's pursue you instead, for the moment. So, this was when, when you had to make a decision? And what happened?

Ho: '94. So '94, I decided to leave. In fact, what happened was, in June of '94, Roger told me, in so many words, that he had embraced Hasan's philosophy. So in July of '94, I decided to leave. And in August of '94, Pacific Care calls me, unsolicited. PacificCare, which was, at that time and still is, HealthNet's biggest for profit competitor, in the same markets with many of

the same overlapping networks. They said, "We want you to take a similar position at PacificCare."

PacificCare's mission, I think, contrasts all of the various things we just talked about. The very simple mission of PacificCare is "to improve the health of our members and ensure the success of our provider partners. So here is a company that, in fact, I felt, and still feel, embodied my values, my goals, equally successful in the marketplace, for-profit, publicly traded, that talked about health care and talked about providers as partners. So this was extremely enticing to me, especially for me. I never have taken any position only as a means of employment; it was really to figure out how to make an impact. So I took PacificCare, and I've been there now over two years. I'm very happy with my opportunity to do the type of strategic planning and development of programs that continually try to make better health care delivery systems.

Mullan: Tell me more about PacificCare, then I want to come back to what you do. I'm still learning my way around the question of who's the provider, who's the payer, who's the plan. Who's got the risk, I guess is an essential issue. Characterize for me how that works in PacificCare, and contrast HealthNet.

Ho: Actually, from a model perspective, as opposed to a philosophical or strategic perspective, from the financial model, most of the non-Kaiser health plans in California have very

similar models. They're basically network-modeled HMOs that rely on a largely capitated--

Mullan: Network meaning IPA?

Ho: Well, network model meaning contracting with medical groups and organized IPAs--so not IPA model in the sense of East Coast IPA model, à la U.S. Healthcare. Because we don't do--very little direct contract with physicians. We go through organized IPAs that have groups--

Mullan: Groups who organize within themselves in some fashion to begin with.

Ho: Exactly. So, kind of a super IPA, if you will. So we go through organized medical entities which are comfortable with assuming more, if not all, of the health premium risk. So it's capitated. It's a capitated network-model delivery system where the plan holds only some of the risk, but basically passes on the risk, mostly, in large part, to the medical groups--which I'm a firm believer of, for a variety of reasons, which, again, would be a subject for a whole subject on the virtues and pitfalls of capitation.

So PacificCare's model is not dissimilar to HealthNet's model, in the sense of understanding network model, contracting with medical group, and seeing capitation as a significant, if not essential, vehicle for managing those groups. The difference

with PacificCare is, it allowed, and it still allows, the opportunity to collaborate with physicians as opposed to confront and be contentious with physicians.

Mullan: How does that work? What does that really mean?

Ho: And because of that collaboration, allow capitation to go beyond a financing strategy. It becomes a public health strategy. It becomes a driver for investment and preventive services and population-based outcomes. So I'm not saying that PacificCare is more altruistic or more visionary than HealthNet, but because of its collaborative philosophy with providers and organized physician groups, just to make sure there's no ambiguity about it, I'm not talking about hospital-led systems, or non-physician. Physician-led organized delivery systems. Because it has that as a basic underlying tenet, it then allows, I think, a more progressive and visionary environment.

Well, how that translates, let's me just throw out some examples. Pacific Care seeks to collaborate wherever it can on any product development--

Mullan: Going on to the next tape.

[Begin Tape 2, Side 1]

Mullan: This is tape two, side one, with Dr. Ho, continued. We lost a little bit at the end of the other tape, so I'm going to

see if we can't go over those hoops real quickly. You were giving me several examples of the product development that represents the values, or the approach, of which product development is one, that represents the values of Pacific Care.

Ho: Right. Some examples of the values, I guess, of how PacificCare, even though it capitates in a network model like the HealthNet or like other plans currently in California--Foundation Blue Cross Plan, which is called California Care, it does more than just capitate. It does percent of premium payment, so that it can share weal and woe with providers, depending on the premium structure.

Mullan: It's a great expression--"weal and woe"?

Ho: Well, I meant up side and down side.

Mullan: Right. And what is it? Weal, as in--

Ho: W-E-A-L. Kind of biblical, actually.

Mullan: Right.

Ho: No, no. What I meant to say was, it was just sharing any upside swings, as well as downside costs beyond an established budget.

Mullan: I'm interested in the expression, because it captures it very well. "Woe" is "woe is me," right?

Ho: We share the pain, right.

Mullan: And "weal" is wealth.

Ho: Yeah.

Mullan: Commonweal. Great expression. Okay. Weal and woe. Gotcha.

Ho: So when premiums are going up, which hasn't been too frequent in the last few years, but when they're up, providers should share in that with a percent of premium. And when they go down, then we share the pain. So there's an up side, down side that both Pacific Care and providers will be similarly aligned. Also PacificCare is the only plan to commit to, and has succeeded in securing, long-term contracts with the provider delivery systems, at least the major provider delivery systems in the state of California. Provider satisfaction surveys. We talked a little bit about that. I can give you the references on those. There's Pacific Business Group and Health, which is the largest purchasing coalition, in conjunction with American Medical Group Association, or the Hospital Councils of Northern, Southern, and Central California. The provider satisfaction surveys all rank Pacific Care at the top, so we're doing something right.

You can be, ironically--well, not ironically to us, but paradoxically to the public sentiment--is that you can be a for-profit company and wear a white hat. You can be values-based, focused on the eight core values of Pacific Care, that include values like "accountability," "integrity," "quality," "people oriented," "continuous improvement," "teamwork," and so on and so forth, and not have shareholder value anywhere in the values statement or in the mission statement. You can actually be successful financially, and take that latter strategy we talked about earlier, that you can be focused on a service industry where providers and health care is your product, and you have to work collaboratively with providers and develop better health care systems.

Mullan: You were telling me a little bit about both the personnel and the demographics of the company, the structure.

Ho: Right, right. The PacificCare's chairman and current president, our founders, are non-physicians. This is not a physician-led company, in the sense of having this chairman of the board as president and CEO. It is a company that wants to do the right thing. For example, not everybody at PacificCare, including its leadership, understands clinical epidemiology, population-based health outcome, regional area variation, provider profile benchmark. They don't understand those concepts, but they understand their mission, to improve the health of our members and ensure the success of the providers.

If we can do that, we will do well as a company. So it allows people like me to easily integrate, in terms of that mission, to really flesh it out.

What does it mean to improve the health of our members and ensure success of providers? It's teaching providers the tools of the service side, as well as the quality side, to practice better medicine. And to improve the health, you have to demonstrate it. It's got to be with metrics that are valid, that can be audited and can be reproduced.

This is just a wonderful environment for someone like me, who has this little smattering of public health, and smattering of practice, and teaching, to look at a systems approach to continually improving the health care, and, of course, the satisfaction of members, because you can't have successful partners, or providers, if you don't have satisfied members. They're two sides of the same coin--service quality and health quality. As somebody has said, the quality of care, as well as the quality of caring. Those concepts have to be merged in a successful managed care organization.

Mullan: And who are the CEO and president?

Ho: The Chairman is Terry Hartshorn, who helped found the company; and the president and CEO is Alan Hoops; and the president of California's operation, who is not a founder, is Jon Wampler; and none of those are physicians.

Mullan: And to whom do you report, then?

Ho: To Jon Wampler. So, my title is Vice President for Health Services, but I'm basically the senior medical officer for the California operation. There's another physician who's the chief medical officer for the entire company. But California is really exciting, more so than Oregon or Washington or Texas, or other states in the PacificCare family. California allows anyone, including myself, the ability to innovate, to really bring out cutting-edge programs, whether it's report card programs, disease management programs in order to meet the needs of a highly competitive marketplace.

Mullan: And the size of the operation?

Ho: In California, we now have 1.4 million members. With the merger of FHP, we'll have 2.4 million members within a couple of months. PacificCare now has two million members nationwide, of which we have 1.4 million. And with FHP acquisition, we'll have 4 million members nationwide. It'll be in the top four HMOs in the country, along with United Health Care, AETNA/ U.S. Healthcare, and Kaiser.

Mullan: How do you spend your time, and how do you like it?

Ho: I spend my time--I work very hard, unfortunately. I work very hard, and I really love it. I love my work. I would say I

work about, average. probably about 70, 75 hours a week. I work, on average, about 13 hours a day, five days a week, and at least one full day on a weekend, which is tough. But what I like about the job, I would kind of divide it, if you look, and this is kind of funny, I look back on my career, but it's about fifty-fifty in terms of 50 percent strategic and 50 percent operational, which is kind of what my job has been, if you look back.

Mullan: By "strategic" you mean planning?

Ho: I'll explain that. Strategic in the sense of planning or developing programs that will continually improve our current system. That might be a contractual program, it might be a report card program, if you will, systems improvement. What do we have now? How are we measuring it? How do we monitor those measures, and how do we continually improve it, whether it's a contracting strategy, a disease management program, a report card? Kind of a systems improvement.

And then 50 percent operation in the sense of, are we taking care of our basic book of business? Are we doing proper medical management? There's tremendous overlap in those two. Are we living up to benchmarks? Are we managing health care costs?

And I like that. I like that combination. Because if it were 100 percent strategic, you're really divorced from the marketplace. You're divorced from the medical groups, you're divorced from the purchasers. That's why I like my job. I prefer my job now, which is a market-based position. A

corporate-based position, which one would think would be very exciting, because it's corporate and you have much more control over policy and you can really develop the templates and the strategic design for innovation, it's removed from the operational element, by definition. You're removed from employers, you're removed from customers, you're removed from providers. And I wouldn't like that dynamic. I like the mix of that. I don't think you can have proper innovation unless you're tied to the marketplace, "marketplace" meaning not just customers, but the providers and employers. So I really enjoy my job.

Mullan: Certainly there's an enormous amount of criticism of managed care--ballot initiatives, legal propositions.

Ho: Media. Legislation.

Mullan: Media. You know, turn on a talk show having to do with health, and get managed-care-bashing going on. Now, you must absorb, directly and indirectly, or be in a position to deal with, respond to that. What is that like? How does that make you feel? How do you handle that?

Ho: It's tough. It's a difficult situation, because quite frankly, managed care is an industry. On the one hand, managed care is an industry that has not fulfilled its potential, and therefore hasn't fully demonstrated improved population health

and cost-effective medicine. It hasn't really fulfilled that potential, and as a consequence, hasn't earned the public trust.

On the other hand, most of what you hear in the papers, even in legislative halls, Congress, state assemblies, is anecdotal. And we've all learned that you can have anecdotal medicine--e.g., you can have anecdotal horror stories about auto safety, and that's frustrating, dealing with anecdotal rebuttals.

But at the same time, it's a tremendous challenge to earn the public trust, to show the demonstrable improvement in population health on a cost-effective basis. I think that's a great challenge. It's not dissimilar from challenges I've faced throughout my career. I like that challenge. I want to be able to earn the public trust. And quite frankly, the industry hasn't made it easy. There are some legitimate horror stories, because you do have, let's just say, different business philosophies that we've talked about which are operative in many of our competitors. So the industry, again, has had some, if you will, flagrant fouls, and talk show and media and legislators have been able to exploit those fouls. So it's an uphill battle.

Mullan: Are you personally responsible for responses or counterattacks? How do you do that other than having good billboards and clever--

Ho: Well, I think it's incremental, a very involved patient process. Basically capture the higher ground and to focus on quality efforts.

Mullan: Is there any hope to demonstrate, in our polyglot system, evidence that the people cared for, that your covered lives have better outcomes than someone else's covered lives?

Ho: I think it would be very difficult to compare. I'd like to answer "yes." I think it's going to be easier to show that people in our system will get better care than they did in the prior health delivery system prior. I think that's the continuous improvement part. But comparison to others' covered lives may be moot. I'm not sure about this. This is a thought.

We live in a very pluralistic society, on everything--multiple airlines, multiple banks, multiple electronic devices. And my feeling--this is just my personal philosophy--it's going to be very difficult, especially in medicine, where advances in technology are democratized and universalized relatively quickly. If you have laproscopic cholecystectomy], within six months the whole country--if it shows cost-effective benefit, within six months, it'll be used. If you use thrombolytic therapy, within a year--

Mullan: Some would argue, even if it isn't demonstrated--

Ho: Exactly. Right. Whether it did or did not, it's going to be universal. So I think it would be overly ambitious, and presumptuous actually, to think that PacificCare's lives would be healthier at some point in time. But I think PacificCare, or in this case, this model, what you can market, if you will, what the

differentiation would be is, you have a consistency that maybe you can't find elsewhere, consistency in service, consistency in health care management, that you have a provider-friendly--I mean, there are some things that you can market and maybe you'd be first to market, that--

Mullan: Satisfaction, both in the provider and the customer sides--

Ho: Right. It's very unique. Yes.

Mullan: And do you do that? Do you measure--

Ho: Yeah, we do a lot. We measure satisfaction all the time. Three times a year.

Mullan: From provider or patient?

Ho: From the provider, we measure it once a year.

Mullan: And the patient, three times a year?

Ho: Yeah.

Mullan: This is like sending your--

Ho: We have an independent surveyor doing it. Our standard issue--we would like to move through the whole movement, in what we call the accountability movement, in managed care, to standardized metrics for everything, everybody doing standardized instrument and design and methodology for patient satisfaction and provider satisfaction.

Mullan: Any hope of getting others to cooperate in that?

Ho: Oh, yeah. I think this accountability movement with NCQA accreditation and AEOIS, and Foundation for Accountability are baby steps in the right direction toward a universal standard. We were very actively involved with that, to promote it, to encourage it, to get towards it. But I think PacificCare will have a niche, a niche that says, yes, you can be for-profit and be member-friendly, provider-friendly, and try to do the right thing, and try to deliver a product--in this case, health care delivery--that's consistent with less variation in the processes and higher outcomes, as measured with bona fide, certifiable results.

Mullan: What do say to the issue that is abroad in the land all the time, and I'm sure you're hit with, you've got these unconscionable salaries, which is something that any member of the public can grab on. My choice is diminished and my access is questionable, and this guy's making 3 million bucks a year. That's what it says in the [unclear]. You know, got a billion

dollars socked away, or whatever. I mean, how does the industry, in general, and you, personally, deal with those charges?

Ho: I think that's difficult. I think they're all difficult charges. I think, first of all, to put it in context, let's talk about the service issues, and then we'll talk about executive compensation. I think on the service issues, about access and choice and insurance benefit, I think you have to be competitive. I think plans have to be accountable to the public and customer and the end-user, the member, to open up access, to open up choice, and to provide a competitive worthwhile benefit that includes preventive services, health education, effective care, and bona fide centers of excellence. On the quality side, you can't have exposure there. Before I get into executive compensation--that that has got to be balanced with the excess capacity. You're really killing the messenger--not you, but the media and the others are killing the messenger. The fact that this country has run amuck with irrational--

Mullan: The story I heard tonight on the news--literally, I didn't get the beginning or the end of it--what is drive-through mastectomies--

Ho: Yes. In Connecticut. I heard that. I think it's Physician Health Plan.

Mullan: Clearly, the industry is testing the market and testing the medical capabilities. I mean, are you going to have drive-through transplants? I think these are reasonable things to test and challenge, but I must say, it puts the industry in a difficult position, and it does appear that, to the extent the hospital is seen as a place of respite and of succor and of healing, here you have an industry that is squeezing and squeezing and squeezing access the hospital. Now, I realize that's a bit more than anecdote, but it's a little less than science.

Ho: Exactly, exactly. So you have to have a balance between succor and respite and sensitivity and the fact that there is tremendous excess capacity. I mean, in the state of California, right now, we know that there are probably 50,000 excess beds, that statewide occupancy on any given day is below 50 percent. And so what the HMOs then become is the messenger. The message is, "Rationalize. Make sure we have the right amount of resources to cover the services that are needed for the right population."

So, on this issue, yes, we have to have a balance. We have to be sensitive. I feel very strongly, you have to be sensitive, you have to develop the succor and the respite. At the same time, we have way too many hospital beds and way too many specialists for what this population needs. At least in urban America. I'm not speaking to the rural issue.

Actually, there's a couple of dilemmas that society is facing. One dilemma is the fact they have virtually, right now, and actually, always have, virtually unlimited demand with a finite supply of resources. So that's one point. The second point is, it's not really a finite supply of resources, it's a maldistribution of resources. This is something we learned in National Health Service Corps so many years ago. How do you deal with unlimited demand, finite resources? How do you deal with maldistribution of resources? Well, one of the ways you do is develop managed care. And yet, oh my goodness, managed care--actually, managed care strikes at, I think, an even more fundamental moral issue in American society, which is a contradictory dilemma. The moral issue is the issue of, in moral terms, equity versus autonomy. The question of the greater good versus individual freedom. So when you raise questions of choice, you're dealing with things fundamental, a fundamental dilemma in American society. You could argue that, except for the public school system and maybe libraries, there are very few things that Americans want for the greater good, and that's, in fact, what managed care represents.

Mullan: The problem with that argument--and I know where you're headed, and it strikes a responsive chord in me--the problem, though, is you've got a hemorrhage out the side, which is called the uninsured.

Ho: Right, right.

Mullan: In other words, if there was a global system, and you said, "We've got only 1 trillion dollars, or 1.3 trillion dollars, or whatever, to spend, and now you've got to manage the sucker, but you cover everybody, and you get some squeezing here. But the simple read, the simplistic read, but frankly, even to me, at this epoch in our history strikes me like the real read, is you've got good management and good waste control going on within the commercial sector, but that money is not, with the exception perhaps of some Medicaid managed care schemes in certain states, the excess is not being then Robin Hood'ed over to the uninsured. It's going flat out into the pocket of certain folks, both individuals and investors. That's the problem.

Ho: Let's Robin Hood it. I'm all for that. PacificCare's all for that. We have a social responsibility. Let's do it. So rather than blaming--and I'm not into blaming the HMOs, even some of the egregiously-oriented HMOs, why don't we come up with a common solution? Who's done that? Has Congress done it?

Mullan: No, they have not.

Ho: Has the president? So why blame HMOs for that, as a failure, an embarrassing, pathetic failure of our society to deal with those issues? It's not HMOs that caused the problem. HMOs could be part of the solution. Well, let's all pitch in, shoulder to shoulder, and find the solution for those 40 million

uninsured. Pacific Care is more than willing to do its part in that.

Mullan: It seems to me the strongest argument that the for-profit HMO world, and, for that matter, the for-profit hospital world, can make in this regard is, "We're setting the stage. We are going to show you that health care costs can be controlled or downlined from this astronomic growth curve they've been on, and now you, you the country, you the Congress, you the President, need to show the political will to design a system that plugs this new way of managing medicine in America into a global solution." Right now we've got the worst of both worlds. In other words, we have a non-global solution. You've got the "haves" getting their butts kicked, and the "have-nots" aren't getting any benefit from it. There are some few exceptions.

Ho: No, I agree with you. We're just setting the stage. I remember, back in 1981, when I brought in an HMO contract to St. Luke's Hospital, I said to the medical staff then, I said, "This is not a panacea, but it's a good transition to dealing with societal problems with access and cost--access, cost, and quality." Gosh, I remember that discussion. It's the same thing now. This is not the panacea. It's a further evolved transition than we had in 1981.

Mullan: So what does one say to the executive compensation?

Ho: Oh, I'll get to that, executive compensation. I couldn't defend a billion-dollar payout, which is what one of our competitors' CEO has, but I can defend a competitive base and a competitive salary for a company in an industry, a competitive industry, trying to attract top talent. If you bring shareholder value, equated to billions of dollars, to a corporation, then an executive compensation in the few millions is relatively competitive with other industries, and a relative pittance, compared to what you're bringing in terms of shareholder--it's a whole concept of value.

For example, we know Dr. David Lawrence is the CEO for Kaiser, not-for-profit. In order to retain a person of David Lawrence's caliber, Kaiser has to compensate about a million dollars a year.

Mullan: Is that right?

Ho: Yeah. That's not-for-profit. Now, a million dollars is measured against two things in terms of Kaiser's overall profit and also how to retain somebody of high caliber. Maybe a million to five million in total compensation including base salary, benefits, etc., is probably the order of magnitude.

Beyond five, beyond ten, you're still dealing--and I'm not going to defend it--I never have, in all the talk shows and interviews I've been on, I'm not going to defend it. On the other hand, there is a perspective to put in, if somebody has helped the company earn, has taken the value of a company from

500 million to 1.5 billion, what's 10 million dollars? It represents one percent of the increased value.

Mullan: That's an interesting argument. That's not the one that I had in mind.

Ho: The problem with it though, people feel, is health care. If this were Microsoft or America Online or Yahoo--

Mullan: Yes, your point of reference is corporate America.

Ho: --big deal. But if it's health care, this is a sacred covenant.

Mullan: Right, except there are those who are critical of corporate compensation in America in general.

Ho: In general, right.

Mullan: And particularly in state industries. I mean, it's one thing when somebody's cowboying it from 500 million to however many billion, but when you've got General Motors kind of lumbering along, losing market share, losing balance of payments, and still their executives are being compensated, in general, I think your point is well-taken, although I think it's still a disturbing one from a populace perspective, and that is, that if your reference point is corporate America, these salaries are not

out of line at all. On the other hand, if your reference point is corporate America, you've bought into, maybe of necessity, a society that has very fulsome awards for a very small leadership cadre that takes it to the bank.

Ho: Right, and that's our anti-populace ideology. So I don't usually defend it from a corporate America perspective. I usually defend it as a way of saying, "We have to attract and retain good talent." And if you don't pay a million, your competitor will pay a million or 10 million.

Mullan: Let me raise one other important issue for managed care, which is something that I know you've thought about. I'm sure you've thought about it. I know you've experienced it. The question of the drying-up of the teaching resource, that both the presence of managed care is squeezing academic medicine in a way that it isn't going to be able to continue to cost-shift and do the things it needs to do, and, secondly, as managed care consumes more and more of the clinical work in America, it has not shown any propensity for allowing in, or inviting in, students, residents. What's the answer?

Ho: I don't know all the answers. I've given it a lot of thought, however. You're right. I think, first of all, in terms of the first point--

Mullan: Why don't we hold on a second, and flip the tape.

[Begin Tape 2, Side 2]

Mullan: This is tape two, side two, Dr. Ho. Our last side.

Ho: Presumably. The first question is, what about academic medical centers and their drying up, and how to you deal with that resource allocation? I think there's a couple of points on that. I think, without being too callous, I think some academic medical centers should dry up. I think our overemphasis on specialization since World War II has outstripped reality. We don't need that many specialists. We don't need that many researchers. I mean, it would be nice, and it's obviously intellectually stimulating, but it doesn't really speak to some of the basic needs of health manpower and distribution that we need in this country.

So, on the one hand, I think some academic medical centers should dry up. I really believe that. I think, for example, in the state of California, we have far too many tertiary care centers than we could possibly justify or rationalize, and I think, yeah, they should dry up. We talked about some of the numbers before, in terms of excess capacity.

The other side of drying up, I think that society has to figure out how it's going to best pay for medical education and advanced training, and I think HMOs should contribute a fair share to that. I really believe that. I also believe that there should be a more rational financial structure that maybe includes a dedicated tax for funding graduate medical education, and not

only coming out of providers, or not only coming out of managed care organizations. Everybody would benefit. Everybody in society benefits from graduate medical education, so everybody should contribute. But it should be a dedicated tax. It shouldn't be lost in the general fund.

So there's two issues there in terms of academic medical centers, in general, but graduate medical education in particular. I think we have to have a more rational design of both academic medical centers and graduate medical education, so that whatever does get dried up, or is shriveled, or shrunk, should be logically designed to meet society's needs, and that there should be probably some kind of general dedicated tax to fund for that.

Mullan: Dedicated tax, that would be an interesting concept, an all-payer tax that would go into some sort of pool to fund education. From your perspective, as it ever has been talked about in the industry, what is the attitude toward that, broadly, and at what point would you tap the system to create an all-payer pool? Taxing premiums? One percent on premiums for medical education?

Ho: I don't know. That's a good thought. I don't think you could fund, necessarily--it's interesting. Let's define "payer." I was thinking of a general tax, among everybody, whether it's income tax, property tax, I don't know what. I don't know how to organize it. But the all-payer tax is an interesting concept,

because, well, who's the payer? Is it the purchaser of health care insurance, which is how the "payer" term originated, or is it risk-bearing insurance company? If it's the purchaser, then we have to look at the government. The single biggest purchaser in the country of health care is still HCFA. Then it goes into all the private employers.

Mullan: HCFA already pays, because it has a graduate medical education component, which is sort of quasi-rational, somewhat irrational, but it argues it already puts in 6 to 7 billion dollars a year, but other payers do not, would be the argument. This is an interesting discussion.

Ho: It's a great discussion. I'd love to have it.

Mullan: Maybe we'll take it up after.

Ho: Yeah. Great discussion. Anyway, so that's the first thing. The first question you raised is, what about the shrinking academic pie, and I say it should be shrunk and it should be rationalized to be more meaningful.

The second thing, HMOs haven't stepped to the plate to participate in the graduate medical education, and I think that's a problem. We have good examples with Group Health of Puget Sound and, to a certain extent, Kaiser. But they could do a lot more than that. So, really, basically re-engineer--this is another corporate term--re-engineer the curriculum of medical

training to be focused on clinical epidemiology, to be focused on outcomes, to be outpatient-oriented. There's tremendous potential there.

Again, the analogy we had in a different context of the discussion is, all we're doing now in 1996 is laying a platform, or a model, or an experiment, for which to cover the uninsured, and for which to cover graduate medical education. That's part of my concept of earning the public trust. We haven't fulfilled that potential. In fact, in most quarters, it hasn't even been raised as a potential. So the fact that we haven't articulated it confirms the fact that we have to redouble our efforts to begin to address those issues. I don't know what the analogy would be, but if we're going to transform, and to a certain extent, tear down something, we should be responsible and accountable for reconstructing something in a better image.

Mullan: That sounds like that's coming from Sam Ho, though, not from the corporate soul of managed care in America.

Ho: Yeah, there are probably some flickers of that.

Mullan: But the fact that there are Sam Hos beginning to populate the corporate structure of managed care in America gives cause for some optimism.

Ho: Some optimism. [Laughter]

Mullan: That's another one to come back to. Primary care, we've drifted away from talking about it for the last hour or two. Let's come back to that, since that theory is what I'm writing about. What do you see as the role of primary care, or what have you seen as the role of primary care, in terms of both HealthNet, PacificCare, for that matter, all of your managed care experience, and how is it changing, or is it changing?

Ho: Again, I see limitless potential for the role of primary care. My experiences have continued to reinforce my original and fundamental belief in the value of primary care, that primary care is cost-effective and is quality-oriented, it's comprehensive. I think all the original definitions of primary care, I think are more valid now than before. I forget which definition it was, but they were accessible, accountable, coordinated, comprehensive and continuous. I think it was two As and three Cs.

Mullan: You got it, right.

Ho: Right. Accessible, accountable, coordinated, comprehensive, and continuity. Those five issues are basic cornerstones, at least for the managed care system that I want to build. I think those are phenomenally valuable watchwords and guiding principles. I think primary care now is better positioned than it ever has been as a specialty, or as a field of medicine, to fully realize its potential as cost-effective, the practice of

quality-oriented medicine. But I don't think it's even close to what it will be, given the information revolution and given the phenomenal technology to enable primary care providers to fully exploit the ability to improve population health and individual health. It's just really exciting.

I'll give you one example. We're very much involved with information technology, the information revolution. There's an example where, right now, the technology exists for an individual primary care physician to use a wireless, palm-top, electronic medical record that feeds into a server connected to a multi-relational database, a warehouse, if you will. So imagine this. A primary care physician can take into an exam room, essentially a browser, a real-time browser, that not only serves as an electronic medical record, but, say, if this patient has multi-system disease--let's say, diabetes, coronary disease, end stage renal disease, on certain medication--that not only could this physician be able to manage information to their patient about the diet and the education and the activities and the wellness things that have to go into that, but on a real-time basis, feeding back to this tremendous data warehouse that can come back and say, on a total population of 2 million, or let's say 20,000, similar risk-adjusted patients that we've evaluated, based on hospital outcomes, functional status, quality of life measures, that right protocol could be immediately accessed. So that primary care physician is further empowered to give even better care than what--

Mullan: So you're saying electronics and information revolution is going to make the primary care provider more capable to handle a wider range of things.

Ho: Yes. I don't know if there's an industrial analogy, but basically, primary care is now better positioned than it ever has been, but it's still kind of dealing with the old methods, like how can Dr. Mullan or Dr. Ho be a great individual doctor, manage all this information, look at this data--

Mullan: Smart enough to handle it all.

Ho: Just be caring enough, and sensitive enough, and understand the cultural issues and the diversity issues, and the community, and be a great doctor. I think now, maybe not so much in history, but now is as good a time as ever for a primary care physician to fulfill that role. But with information technology, it can take it to a whole different level, where this primary care physician really becomes a phenomenal orchestra conductor for a huge symphony instead of a three-piece band or a five-piece band, that we haven't even begun to tap. This is so exciting.

So I think the future is very, very bright for primary care physicians, including rural-based physicians, or urban-based or people in multi-specialty medical groups, because technology is going to be the true enabler and empower physicians to make even better decisions, working in partnership with their patients.

Mullan: I talked to Stan Padilla, and he began to tell me about it, and then I heard a couple of ads, and I didn't even hear who they were from. I haven't quite picked up the terminology, but the bypass option, to get by your primary care provider, which is now apparently an attractive market.

Ho: Yeah, I don't believe in that.

Mullan: But that is a coming, I gather, phenomenon?

Ho: That's Stan Padilla's mix. See, Stan is at HealthNet, and that's one of their major strategies. I don't believe in that. I believe in going through the primary care physician. For example, we know, from our market research, that specialty referral is--and you don't have to be a rocket scientist to get this--is one of the major complaints, in fact, it's the leading complaint for our model of HMO, amongst members.

Mullan: You mean, not getting the specialty referrals they think need, that they want?

Ho: Right, right. So, Stan Padilla's plan. his company, my former company, believes in "Yeah, let's bypass this PCP. Let's let patients go directly to the specialist." T Pacific-Care we developed a program called, Express Referral, where you still go to the PCP, but if that PCP deems a referral is necessary, you bypass the UR committee. You still get to see the specialist,

you get to see him quickly, as quickly or more quickly than you would under fee-for-service, but you still have to go to the PCP first. I think there's going to be some divergent roads there, and Stan Padilla and others think that, with technology, you don't need a PCP. I say, "Hogwash." I really believe in a PCP. I believe that coordinated care is better than non-coordinated care, because I believe in primary care.

Mullan: There are others who have articulated the nurse practitioner and the specialist, and you don't need a PCP.

Ho: Well, there's probably some truth to that, in terms of preventative services. I think the nurse practitioner is a provider in the PCP grouping. I've heard that argument. I'm not in a point to dispute it. I'm really disputing direct access to the specialist. Because who's going to take care of the patient's preventive health care needs? Specialists haven't been trained, and won't be trained, in that. Or the family needs, in the family practice cases? So I think a good nurse practitioner and a specialist would be okay. I think that's somewhat splitting hairs. I still believe in a PCP model, which includes personal care physicians and nurse practitioners..

Why would you use a primary care physician versus a non-physician? Because there are degrees of complexity, prescribing. But you won't need the physician to do more sophisticated data management, because that will be solved electronically at some

point, pretty soon, within the next decade. So, I think, degrees of complexity.

Mullan: My own belief is that we're going to see some changes there, and my catechism has the PCP at the top, but I think nurses are climbing the food chain very effectively.

Ho: The PCPs are staying at the same level.

Mullan: Yes. I mean, they're broadening their kind of activities. And certainly in some cases you hear PCPs complaining that the amount of acuity they're dealing with, because they're not referring as much, they've moved up, in terms of amount of acuity, and the nurse practitioner's handling the simpler stuff.

Ho: And if you ever right-size the delivery system, to get rid of excess specialists, there would be lots of room for both PCPs and nurse practitioners--I agree with you.

Mullan: But I think there's going to be some settling-out between the nurse practitioner, the PA, and the primary care doc. We haven't seen that sort of settle out, and I don't know how it's going to be. What's your future? What do you see for the future of Sam Ho?

Ho: My personal future? I don't know. If you look at that, there should be a change sometime soon. Every two or three years, I change. I like my current job. I like it very much. I think it's a tremendous opportunity. My recent analysis, or what you'd call review of the landscape in health care, in terms of, again, my ability to make an impact versus my degrees of constraint in doing so, I think, currently, the best way for me to make change in health, continue to improve health care delivery systems in this country, to hopefully improve population health, is going to be on the plan side. I think plans have more sophisticated understanding of the customer and marketplace. I think health plans have a more sophisticated information system, infrastructure. I just think, for me, that, for the foreseeable future, I will stay on the plan side.

Mullan: As opposed to?

Ho: Providers, pharmaceutical companies, consulting, start-ups. I think, given my level of expertise and my understanding of the industry, my contribution, for the foreseeable future, will be on the health plan managed care organization side. I think that's a nice niche for me to be in. I think I still see myself in the senior medical officer class. I don't see myself as a CEO. You have all these opportunities once you are on the plan side. I see myself in the senior medical capacity, looking at continual systems improvement, whether that's using information systems or clinical management systems. I like that.

Mullan: So the public health side of things, or the health--

Ho: I don't see myself going back into academics or public health. I've done it before. I've gone into the public sector.

Mullan: You certainly have.

Ho: I can't see it in the foreseeable future, because there are so many degrees of constraint--budgetary, number one; political, number two. But, for example, blue-skying it, if we had political will amongst policy-makers on the public side, really dealing with the uninsured, and, if you will, helping create a more level playing field, where public sector delivery systems could have the chance to succeed, I could see myself going back and dealing with the challenge. But I'd say that's not likely in the next few years. Lifetime--no, the next few years. So I'm staying on the plan side for a while.

I've thought about things like pharmaceutical company areas, going on the provider side, which are getting larger and more and more sophisticated, start-up companies in terms of the technology companies, I could help the enablers. I don't think any of those, right now, give me an effective enough platform to institute change. In the next five to ten years, I think the provider side will be much more developed and actually will be a good answer, because that's where the true solutions are going to lie, going to be with doctors.

Mullan: So in five or ten years, it will be more developed?

Ho: At least five to ten years, it will much more developed, and that will be exciting. I think it will be an exciting opportunity, because I really believe that the foundation for all of these health systems is the doctor and the patient, and so that's where the solutions will come from.

Mullan: Could you have done what you have done if you were a neurologist, if you were not a PCP?

Ho: No, no.

Mullan: Why?

Ho: No, I don't think so. I once hd a similar conversation with a neurologist. I had this conversation with him once, and I'd come in and joke. He didn't take it as funny. I said, "You know, the issue of the neurologist is really focused on analysis paralysis." You know, everything about a diagnosis--most of time, you can't do anything about it. Whereas, primary care physicians, we really know many things about many diagnoses, I mean, maybe less about many diagnoses, but you're actually able to do something about it, because you're dealing with issues related to non-medical concerns as well--social medicine, community medicine, public health medicine, prevention.

I really think that primary care--my story is not unique, but somewhat peculiar, because not only couldn't I have done what I've done because of the broad perspective that primary care has given me, but the breadth and the depth, in terms of non-medical solutions, and looking at systems, but, preceding that, my only commitment to go into primary care was a commitment to make societal change, improve the life and welfare of more, not fewer. So those two coupled together, I think, really gave me the mind-set and then the skills to develop a systems improvement perspective. I really want to continue to improve it.

Mullan: On the personal side, I gather you've gotten remarried?

Ho: Remarried. Only a year now.

Mullan: How's that going?

Ho: Good. Stepchildren a little challenge, but--

Mullan: Do you have children by--

Ho: Yeah. My first wife and I were together about twenty years. I have a son who is a senior in college, and daughter who is a senior in high school. My son is in Northern California. My daughter and my first wife live in San Francisco, which was where I spent most of my career. And then my second wife, my new wife, is in L.A.

Mullan: Did your career work hard on the marriage, in particular?

Ho: Yeah, you know, I don't know if it's the career or it was me. I've learned more about--we've all learned more about ourselves as we grow older. I think my first marriage, the career might have been an excuse. I mean, I've always worked these hours, I've always been driven by a vision and a passion that are relatively--in the HMO parlance--it's an outlier status. Really, beyond what most people I know are about. I don't know if that's the cause. I think my first wife and I still remain very, very good friends, but we just drifted apart and didn't share a common romantic approach to each other. We're still friends. In a lot of ways, we're more like a brother and a sister. We grew up together. We grew up from the sixties to the nineties, and didn't maintain the romantic flame, but we still maintain the intellectual friendship type of affinity.

I don't know if it was work. I mean, I think it was easy. I think when we divorced several years ago, and when we were separated, it was easy to blame work. I would consume myself in work, work was accused of being my mistress, but I don't know if that was the cause or the symptom of underlying differences.

Mullan: How about your folks? Are they still alive?

Ho: My dad passed away five years ago. My mom's still alive, vigorous, active, wonderful. She just had a mastectomy for

breast cancer. She's amazing. She went through a mastectomy and prosthesis. She's doing great. She lives in Honolulu. I call her once a week. She went to New England for a high school reunion about two months after her mastectomy. She's a wonderful, wonderful role model in terms of *joie de vivre* and just human capacity for enjoyment of people. She's just a great person.

Mullan: Well, you've been terrific. It's been a great interview. Somehow I think it ought to be on Charlie Rose, or something. I think we're hitting on some good topics. Anything else we haven't touched on that you have?

Ho: No, I think you covered it all. I can't imagine you sitting through seventy-one of these tapes.

Mullan: We'll stop it at that.

[End of Interview]